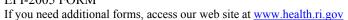
## Rhode Island Department of Health Reportable Disease Confidential Case Report Form

For use by providers of clinical care EPI-2005 FORM





## State of Rhode Island and Providence Plantations Department of Health 3 Capitol Hill – Room 106

**Providence, Rhode Island 02908-5097**Phone: (401) 222-2577 After hours reporting: 401) 2'

one: (401) 222-2577 After hours reporting: 401) 272-5952 Fax: (401) 222-2477; (401) 222-2488

Name of Patient (Last)		(First)	(MI)		Patient's Home Address (No. and Street)							
(City or Town)		State	Zip code		Birth date	Age			Patient's Telephone:			
					/ /				( )	-		
Race   American	Indian/Alaskan Native	☐ Native Hawaiia	n/Other Pacific Isl	lander	Hispanic or Latino:	Sex:	☐ Male		Did patient die of		Yes	
☐ Asian		□ White			□ No		☐ Female		this illness?		No	
☐ Black or A	African American	□ Unknown			☐ Unknown		□ Unknow	n			Unkr	nown
Is patient a: (please check)					If yes, name and address of workplace, s	chool or d						
☐ Health Care Worker ☐ Student												
☐ Day Care	e Worker/ Day Care Atter											
Name of disease: Clinical Onset Date Lab Diagnosis Date					Viral Hepatitis							
LYME DISEASE (N	NEW ONSET)				IgM anti-HAV		Positive		Negative		Not D	
		/ /	/ /	/	HBsAg		Positive		Negative		Not I	
Confirmatory laboratory data, immunization status (esp. for pneumococcal and meningococcal					IgM anti-HBc		Positive		Negative		Not E	
invasive disease), dates and comments (be specific):				Chronic HbsAg carrier ELISA anti-HCV		Yes Positive		No Negative		Unkn Not D		
					RIBAHCV				Negative			erminate
					RT-PCR HCV			Genotype				
					Γ (AST):		SGPT (AL		Bilirub			
Reporting provider's na	ame (print)				Sexual preference  History of IV drug use	Heterosex		Homosexu Yes	al 🗆 Bisexuai			Jnknown Unknown
						Yes- Patie	ent is pregnant		exual partner is pregi	nant		Unknown
							Lyme Disea		P			
					ERYTHEMA MIGRANS:							
Phone Number: (	)				Physician diagnosed EM 5 cm (2 in)	?		□ Yes	□ No		□ U	Jnknown
If hospitalized,	Hospital (Name, City, St	tate):	Patient Medical		RHEUMATOLOGIC							
date admitted:			Record #		Arthritis (objective joint swelling)			□ Yes	□ No		□ U	Inknown
					NEUROLOGIC							
/ /					Bell's palsy or other cranial neuritis	)		□ Yes	□ No			Unknown
					Radiculoneuropathy?			□ Yes	□ No			Unknown
Additional comment	t <mark>s</mark> :				Lymphocytic meningitis?			□ Yes	□ No			Unknown
					Encephalitis/Encephalomyelitis?			☐ Yes	□ No			Unknown
					Antibody to B. burgdorferi higher in	n CSF thai	n serum?	☐ Yes	□ No			Unknown
					CARDIOLOGIC							
					2 <sup>nd</sup> or 3 <sup>rd</sup> degree AV block?			☐ Yes	□ No			Unknown
					OTHER HISTORY							
				Name of antibiotic used this episode	?							
( Please print)					LYME DISEASE LABORATORY REP	ORT MU	ST HAVE					
Name of person compl	eting report for provider:				POSITIVE WB TO REPORT							
vor percent compr												
Address:												
Telephone: (		Report Date	. / /		Western Blot □ Posi	tive	□ Ne	pative	□ Equivocal			Not Done